

# Women & Infants' Fertility Center



90 Plain Street, Providence RI 02903  
Tel 401.453.7500 | Fax 401.453.7598  
fertility.womenandinfants.org

Hello!

We would like to welcome you to the Women & Infants Fertility Center. Our main office is located at 90 Plain Street, 4<sup>th</sup> Floor, Providence, RI. We also see patients at the Women & Infants Medical Office building at 1050 Main Street in East Greenwich, RI.

Our physicians work as a team to enhance the care we provide. In addition, Women and Infants is one of Brown University School of Medicine's premier teaching hospitals and, as such, residents and medical students may be involved in your care under our direct supervision.

Enclosed please find some documents regarding treatment at our facility including the following:

- Patient Questionnaire and Patient Demographic Sheet
  - Complete and hand carry these forms to your initial appointment
- Patient Checklist
  - Carefully review this form prior to your appointment so that your initial appointment is as productive as possible.
- Patient Insurance Coverage information
  - Carefully review this form; it is intended for you to use as a guideline to contact your insurance carrier to discuss coverage for potential treatment at our facility
  - Please complete and carry the acknowledgment only to your initial appointment; the first two pages are for you to keep as reference

Please arrive 15 minutes early for your initial visit to our office to facilitate registration. Directions to your appointment can be found on our website. Your partner is encouraged to attend this visit and all subsequent appointments.

If you need to cancel your visit, please call us at 401-453-7500 at least 72 hours prior to your appointment.

We look forward to participating in your care. If you have any questions, please call and our dedicated staff will be more than happy to assist you.

Sincerely,

The Physicians and Staff  
Women & Infants Fertility Center

## WOMEN & INFANTS' FERTILITY CENTER (401) 453-7500

**Ruben Alvero, MD**, is the director of the Division of Reproductive Endocrinology and Infertility (REI) in the Department of Obstetrics and Gynecology at Women & Infants Hospital of Rhode Island and The Warren Alpert Medical School of Brown University. A graduate of Harvard University, Dr. Alvero earned his medical degree at the F. Edward Hebert School of Medicine, Uniformed Services University of the Health Sciences in Bethesda, MD. He completed a residency in obstetrics and gynecology at Walter Reed Army



Medical Center in Washington, DC, and a fellowship in reproductive endocrinology and infertility at the National Institutes of Health. A fellow of the American College of Obstetricians and Gynecologists (ACOG) and the American College of Surgeons, Dr. Alvero is a member of the American Society for Reproductive Medicine, the International Gynecologic Society, the National Hispanic Medical Association, the Society for Assisted Reproductive Technologies, the Society for Reproductive Endocrinology and Infertility, and the Society for Medical Decision-Making.

**Lynae M. Brayboy, MD**, attended medical school at Temple University School of Medicine. Dr. Brayboy completed her residency at Abington Memorial Hospital. During the research portion of her fellowship, Dr. Brayboy was selected from an international pool of candidates to participate in the Frontiers in Reproduction Course at the Marine Biological Laboratory in Woods Hole, Cape Cod. In three short years, Dr. Brayboy has published her basic science thesis on oocyte protection from chemotherapy, obtained \$165,000 in private and federal funding for her research, designed an app called *Girl Talk* to teach adolescent girls about sexual education, and won the National Institutes of Health Loan Repayment Award for Research for her research in Infertility and Contraception. Dr. Brayboy is currently an assistant professor (Research Track) supported by the Reproductive Scientist Development Program/National Institute of Child and Human Development. Her interests include oncofertility, pediatric and adolescent gynecology, and menopausal medicine.



**John E. Buster, MD**, earned his medical degree from the University of California at the Los Angeles School of Medicine where he also completed residency training in obstetrics and gynecology and fellowship training in reproductive endocrinology and infertility. Board-certified in obstetrics and gynecology and reproductive endocrinology, he is a professor at The Warren Alpert Medical School of Brown University. Dr. Buster's clinical practice focuses on infertility, assisted reproductive technology, reproductive surgery, and menopausal hormone replacement. He is internationally recognized for having achieved the world's first successful pregnancy using blastocyst transfer. He has special expertise and has earned international recognition for his work in preimplantation embryology, ectopic pregnancy, and female hormone replacement.



**Eden Cardozo, MD**, attended medical school at the University of Michigan Medical School in Ann Arbor after majoring in molecular, cellular and developmental biology at Yale. She was a resident at the Northwestern University Feinberg School of Medicine in Chicago, and a fellow at Harvard Medical School's Massachusetts General Hospital. Dr. Cardozo's research interests include fertility preservation and the impact of obesity on reproductive outcomes. She serves as an ad-hoc reviewer for the *Journal of Assisted Reproduction and Genetics* and is an active member of the Team Fox Young Professionals of Boston at the Michael J. Fox Foundation for Parkinson's Research.



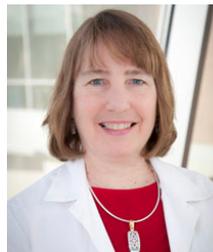
**Gary Frishman, MD**, attended medical school at Columbia University in New York City. Following this, he completed a residency in obstetrics and gynecology at Pennsylvania Hospital in Philadelphia and a fellowship in reproductive endocrinology and infertility at the University of Connecticut in Farmington. Dr. Frishman joined the Division of Reproductive Endocrinology and Infertility at Women & Infants in 1991. He is board-certified in obstetrics and gynecology and reproductive endocrinology and infertility. Dr. Frishman's research interests include hysteroscopy and uterine surgery and medical education. He is also actively involved in resident and medical student education and research and is the Ob/Gyn Residency Program Director.



**Victoria Snegovskikh, MD**, received her medical degree from I. P. Pavlov State Medical University of St. Petersburg in Russia and Karaganda State Medical University in Kazakhstan. Her postgraduate training includes a rotating internship and residency in obstetrics and gynecology at St. Petersburg Medical Academy of Postgraduate Education in Russia. Dr. Snegovskikh also completed a residency in the U.S. with the Yale University School of Medicine in obstetrics and gynecology. She is board-certified with the American Board of Obstetrics and Gynecology and board-certified in Obstetrics and Gynecology in Russia. Dr. Snegovskikh's research interests include changes in cervical mucus and saliva in patients undergoing fertility treatments, cervical mucus as a barrier against infection during pregnancy and identification and characterization of membrane progesterone receptors in fetal membranes.



**Carol Wheeler, MD**, earned her medical degree from Jefferson Medical College in Philadelphia, PA. She did her residency training in obstetrics at Miami Valley Hospital in Dayton, Ohio, and her fellowship training in reproductive endocrinology and infertility at the Hospital of the University of Pennsylvania. She practiced in New Orleans, Louisiana prior to coming to Women & Infants in 1990. She is board-certified in obstetrics and gynecology and reproductive endocrinology. She is the director of the Third-Party Reproduction Program and the Pediatric and Adolescent Gynecology clinic. She is currently the director of the Fertility Preservation Program, which assists women dealing with cancer and fertility concerns. Active in teaching of trainees at all levels, Dr. Wheeler functions as a mentor for many future obstetricians and gynecologists and is happy to share her knowledge and experience.



**Women & Infants**  
A MEMBER OF CARE NEW ENGLAND



**Women & Infants' Fertility Center**  
90 Plain Street, Providence RI 02903  
mailing: 101 Dudley Street, Providence RI 02905  
phone: 401-453-7500 | fax: 401-453-7598

**Women & Infants Hospital**  
**Division of Reproductive Medicine and Infertility**  
**Gynecologic Patient Questionnaire**

**If you need help filling out this form, please contact us and we will have someone help you. You may be asked to come in ½ hour earlier than your scheduled appointment to answer your questions.**

**Identifying Information**

Name \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name by which you wish to be addressed: \_\_\_\_\_ Date of Appointment: \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

Which number do you prefer we call you at and leave a voice message? Home: \_\_\_\_ Work: \_\_\_\_ Cell: \_\_\_\_

Home phone number: (\_\_\_\_) \_\_\_\_\_ Cell number: (\_\_\_\_) \_\_\_\_\_

Work phone number and hours: (\_\_\_\_) \_\_\_\_\_ ext: \_\_\_\_\_ hours \_\_\_\_\_

Can we have permission to leave a confidential message concerning your treatment?

Work: Yes \_\_\_ No \_\_\_ Home: Yes \_\_\_ No \_\_\_ Cell: Yes \_\_\_ No \_\_\_

Partner's name (if appropriate) \_\_\_\_\_ Birth date \_\_\_\_\_

Age \_\_\_\_\_ Occupation \_\_\_\_\_

Pharmacy name and phone number: \_\_\_\_\_

Referring Physician (name and address): \_\_\_\_\_

Gynecologist IF different from above (name and address): \_\_\_\_\_

Chief Complaint (reason for visit): \_\_\_\_\_ If Infertility Duration: \_\_\_\_\_ yrs.

Would you like us to contact you if an earlier appointment becomes available? YES \_\_\_ NO \_\_\_

**I. General Information**

Are you:  Single  Married  Long term relationship  Separated  Divorced  Remarried

Years with present partner \_\_\_\_\_ Date of marriage (if applicable) \_\_\_\_\_

Either partner previously married or had previous pregnancies? Yes \_\_\_ No \_\_\_ If yes, please explain: \_\_\_\_\_

Why would you like to be evaluated at Women and Infants'?

- |  |  |
|--|--|
| <input type="checkbox"/> Delayed or absent periods     | <input type="checkbox"/> Irregular or abnormal periods |
| <input type="checkbox"/> Endometriosis                 | <input type="checkbox"/> Recurrent miscarriages        |
| <input type="checkbox"/> Excessive hair growth or loss | <input type="checkbox"/> Pelvic pain                   |
| <input type="checkbox"/> Fibroids                      | <input type="checkbox"/> Premature menopause           |
| <input type="checkbox"/> Infertility                   | <input type="checkbox"/> Other _____                   |

If you are trying to get pregnant, how long have you been trying to conceive? \_\_\_\_\_

**II. GYN History**

Age of first period? \_\_\_\_\_ Date of most recent period (1<sup>st</sup> day) \_\_\_\_\_

Are your periods regular? \_\_\_\_\_ Yes \_\_\_\_\_ No

Usual number of days between periods: \_\_\_\_\_ Usual duration of bleeding: \_\_\_ days

Amount of flow? (please circle): Minimal Moderate Severe

Cramps? (please circle): Minimal Moderate Severe

Is pain medication necessary? <i>If so what type:</i>	Yes	No
Are you aware of ovulation?	Yes	No
Do you have Pelvic Discomfort?	Yes	No
Do you feel that you have excess hair growth (hirsutism) or acne?	Yes	No
Previous methods of contraception: ( circle all methods used) Pills, Condoms, Foam, Diaphragm, IUD, Withdrawal, Rhythm, None		

Usual frequency of sexual intercourse per week \_\_\_\_\_ or per month \_\_\_\_\_

Lubricants used: Yes \_\_\_ No \_\_\_ If yes, please specify: \_\_\_\_\_

Does your partner ejaculate in the vagina during intercourse? Yes \_\_\_ No \_\_\_

Do you douche \_\_\_ before or \_\_\_ after intercourse? Yes \_\_\_ No \_\_\_

Is intercourse painful or difficult for you or your partner? Yes \_\_\_ No \_\_\_

If yes, please check all that apply:

- Pain is:  Mild,  Moderate,  Severe,  Always painful,  Rarely painful,  
 With all sexual positions  Just with some positions,  
 Getting worse with time  No change in last few years.

Do you have a history of DES (*diethylstilbestrol*) exposure? Yes \_\_\_ No \_\_\_

Date of last pap smear \_\_\_\_\_ Results \_\_\_\_\_

Do you have a history of an abnormal pap smear? Yes \_\_\_ No \_\_\_

If so, have your recent pap smears been normal? Yes \_\_\_ No \_\_\_

History of: Pelvic pain \_\_\_ Endometriosis \_\_\_ Pelvic Infection (PID) \_\_\_ Chlamydia \_\_\_ Herpes \_\_\_  
 Syphilis \_\_\_ HPV(genital warts) \_\_\_ Gonorrhea \_\_\_ Tuberculosis (TB) \_\_\_

How many sexual partners have you had in your lifetime? \_\_\_ I have never had intercourse \_\_\_ 1 \_\_\_ less than 5 \_\_\_ 5 or more

**III. Obstetrical History**

Have you ever been pregnant? Yes No If yes complete the following:

Month/Year Pregnancy Ended	Pregnancy Outcome* see below	With Current Partner?	Infertility Therapy (if so, type)	How long to Conceive	Sex (M/F) and weight of baby (if delivered)	If Miscarriage was a D&C done (Y/N)?	Were there any complications with the pregnancy (Y/N)?
		Y N					
		Y N					
		Y N					
		Y N					
		Y N					
		Y N					

\*V-Vaginal delivery, CS-C-Section, M-Miscarriage, TOP - Termination of Pregnancy, TA-Therapeutic Abortion, EP-Ectopic/tubal Pregnancy

**IV. Past Medical History and Review of Systems**

Have you ever had any procedures on your cervix such as biopsy, cauterization, cryosurgery, D&C (if yes, please specify)?	Yes	No
Any procedure on uterus, vagina, tubes, ovaries, or operations for inflammatory or infectious pelvic diseases, operations for adhesions or endometriosis?	Yes	No
Have you ever had a Laparoscopy? _____ Hysteroscopy? _____ If YES when? _____	Yes	No
Have you ever had stimulation of ovulation with oral or injectable agents such as clomiphene (clomid, serophene), HCG, gonadotropins, FSH (if yes, please circle what used)?	Yes	No
Have you ever had any treatment of endometriosis with drugs?	Yes	No
Have you ever undergone artificial insemination: if YES, with: Partner _____ or Donor _____	Yes	No
Have you ever had an endometrial biopsy and, if yes, when?	Yes	No
Have you experienced depression or anxiety related to your condition?	Yes	No
If you experienced depression/anxiety related to your condition have you received psychological treatment for it?	Yes	No
Have you used alternative medicine for infertility (herbs, acupuncture, etc)?	Yes	No
Do you have a heart murmur or condition which routinely requires antibiotics with all surgical or routine dental procedures?	Yes	No

Do you have any other significant medical history? If yes, please write down on the back of this form . Yes \_\_\_ No \_\_\_

**Please list any present medications that you are currently taking:**

Name	Purpose

Are you taking vitamins containing Folic Acid or a Folic Acid supplement? Yes \_\_\_ No \_\_\_

Do you have allergies to Medications?:  Yes  No If so, please complete the following:

Medication	Type of reaction	Date

Do you have any other significant allergies?: \_\_\_\_\_ Date \_\_\_\_\_ Reaction/Symptoms \_\_\_\_\_

	Yes	No	Date	Reaction/Symptoms
Latex				
Food(s) such as eggs, peanuts, iodine, shellfish. List:				
Environment List:				

Present weight: \_\_\_\_\_ lbs. Weight 2 yrs ago: \_\_\_\_\_ lbs. Exposure to significant chemicals or x-rays: Yes \_\_\_ No \_\_\_

Smoking habits: Yes \_\_\_ Number/day \_\_\_\_\_; No \_\_\_ If stopped, when \_\_\_\_\_

Caffeine intake:Cups/day: Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Cola \_\_\_\_\_ Alcohol: Describe your intake: \_\_\_\_\_

Exercise (type, duration, how often): \_\_\_\_\_

Use of marijuana, opium or other non-medical or recreational drugs: Yes \_\_\_ No \_\_\_ If yes, current \_\_\_ or past \_\_\_

Have you ever been the victim of sexual or physical abuse? Yes \_\_\_ No \_\_\_

If yes, have you received counseling for this? Yes \_\_\_ No \_\_\_



Please be aware that our practice does not provide primary care services (for example: pap smears and other routine health screens and issues) and we request that you obtain this care from your primary care physician and/or gynecologist. Please describe the services which you hope to receive from our practice:

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Please note any other questions or issues which you would like to discuss with your doctor:

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The above information is correct.

Signature \_\_\_\_\_

Date \_\_\_\_\_

From time to time, television or other media interviewers request to speak to one of our patients concerning advances in treatment or other issues. Although we NEVER give out our patient's names or allow an interview without their permission, please indicate below if you would be willing to be contacted by our office to consider an interview in the future.

\_\_\_\_\_ Please feel free to contact me concerning an interview. I understand that I will ALWAYS have the right to say no and that my name and/or picture will NEVER be used without my permission.

# Women & Infants' Fertility Center

## Patient Checklist

- Medical Records
  - In order for the physician to perform a complete evaluation at the time of my appointment it is necessary to have medical records from my referring doctor in addition to results of all prior testing at the time of the appointment. Please arrange to have any medical records pertaining to your reproductive health, including any operative notes mailed or faxed to our office at least 2 weeks prior to your appointment.
    - Records can be faxed to our confidential fax line by faxing 401-453-7598
    - Records can be mailed to our office Attn: Women & Infants Fertility Center, New Patient Records, 101 Dudley Street, Providence, RI 02905
    - Please contact our office at 401-453-7500 five days prior to your appointment to confirm that your records have been received.
    - Please be aware that due to HIPAA regulations, once we have received your medical records we will be unable to return a copy to you so please retain a copy for yourself
  
- Insurance Worksheet
  - I have reviewed the Insurance Worksheet and have contacted my insurance company to see which diagnostic procedures and treatments are covered and whether there are any limitations to treatment. I understand that it is my responsibility to know which services are covered by my insurance company, and that the financial counseling staff will assist me in interpreting the coverage if I have any questions.
  
- Insurance Referral
  - If my insurance requires a referral, I have obtained it from my primary care physician prior to my visit. They can fax the referral to 401-277-3672.
  
- Folic Acid Supplements/Prenatal Vitamins
  - I am aware that both a folic acid supplement and prenatal vitamin are recommended prior to conception. Both of these supplements are available over the counter; please check with your pharmacist if you have any questions.
  
- Pre-Conception Screening
  - I have read the enclosed pamphlet on pre-conception counseling and will discuss this with my physician if I choose to proceed. I am aware that my insurance company may not cover the cost of this elective test.
  
- Directions
  - I have directions to the office in Providence at 90 Plain Street 4<sup>th</sup> floor (I am aware that this location is not at the main Women & Infants Hospital site) or in East Greenwich at 1050 Main Street.

# Women & Infants Fertility Center

## Insurance Information & Worksheet

We have found that one of the most common problems that patients face when seeking treatment with us is finding out what treatments their health insurance policy will cover and what their out of pocket expenses for treatment will be.

**As it is your responsibility to know what services are covered by your insurance policy, the information provided below can be used as a tool to contact your insurance company directly in order to learn about your coverage prior to your initial consultation. Our financial counseling staff will gladly assist you in understanding and interpreting the coverage to our best ability so you can make informed decisions about your treatment.**

If you choose to proceed with treatment at our facility our financial counseling staff will review your insurance coverage to determine if authorization is required and if so we will submit a request for authorization on your behalf. Please be aware that it can take up to 15 business days to obtain authorization so it is important that you speak with a financial counselor as soon as you know that you will begin a treatment cycle. Most insurance carriers require a new authorization with each cycle.

Please note that if you are having any bloodwork done at a facility outside of Women & Infants you must make sure that your care team is aware of this so that your bloodwork is not repeated here.

**Please be aware that it is the policy of Women & Infants Hospital that all balances with the hospital must be paid in full prior to proceeding with elective treatment which includes any fertility treatment cycles.**

Your services are billed through Care New England's Professional Billing Office (401-273-0641) for office visits and Patient Financial Services (401-921-7200) for bloodwork, ultrasounds, procedures and treatment cycles. If you have questions regarding open balances or if you have questions after receiving a statement for services provided you should contact the appropriate billing office directly for clarification; if you have additional questions after speaking with either of those offices you can call us directly and we will assist you in attempting to resolve any issues.

### Questions to ask your insurance company

There are several factors that impact whether you are eligible for infertility treatment. When contacting your insurance carrier please be sure to specify the duration of your infertility, your marital status, and any prior sterilization of yourself and/or your partner (tubal ligation or vasectomy) if applicable.

- Is my physician in-network? (provide your doctor's name). If my physician is not in-network do I have out-of network coverage and if so is my patient financial responsibility higher for out-of network services?
- Is Women & Infants Hospital in-network as a facility?
- Do I have a deductible and/or Out of pocket maximum? Do these run on a calendar year or a plan year basis?
- Do I need a referral from my PCP (Primary Care Physician) in order to seek treatment for infertility from a reproductive endocrinologist? (If yes please contact your PCP and ask them to fax a referral to our office at 401-453-7664).
- Do I have coverage for evaluation and diagnostic testing for infertility including surgery if necessary? (Make sure to indicate that services are being performed in an outpatient facility setting)
- For infertility medications (ie: Clomid, Follistim, Gonal-F, HCG, Repronex, Bravelle)
  - Is prior authorization required?
  - What is my patient financial responsibility (co-insurance)?
  - Is there an annual and/or lifetime maximum for this benefit?
- For the following procedures Artificial Insemination (CPT Code 58322), In Vitro Fertilization (IVF) (S4015 or 58970), Frozen Embryo Transfer (S4016), Cryopreservation (CPT 89258) and ICSI (CPT 89280)
  - Is this a covered service?
  - Is prior authorization required?
  - What is my patient financial responsibility (co-insurance) for these services when performed in an outpatient setting?
  - Is there an annual and/or lifetime maximum for this benefit?
- What is my patient financial responsibility (co-insurance) for bloodwork and ultrasounds performed with an infertility diagnosis when performed in an outpatient setting?

I have received the above information and understand that it is my responsibility to contact my insurance company directly to verify my coverage for any treatment received at the Women & Infants Fertility Center.

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Patient Name

Patient Signature

Date

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Hospital Representative Signature

Date

**INSURANCE BENEFIT VERIFICATION WORKSHEET**

Policy is on:      PLAN YR      CALENDAR YR

Deductible: \_\_\_\_\_ OOP Max: \_\_\_\_\_

Specialist office visit co-pay: \_\_\_\_\_ Do I need a specialist referral? \_\_\_\_\_

Co-insurance for fertility services performed in an Outpatient Facility: \_\_\_\_\_

Co-insurance for labs (bloodwork) performed in an Outpatient Facility: \_\_\_\_\_

Co-insurance for diagnostic imaging (ultrasounds) performed in an Outpatient Facility: \_\_\_\_\_

Is authorization required for:

Intrauterine Insemination (CPT 58322)

In-Vitro Fertilization (CPT 4015)

Sperm Injection (CPT 89280)

Frozen Embryo Transfer (CPT S4016)

Cryopreservation (CPT 89258)

Are there any exclusions on my policy? \_\_\_\_\_

Are there any cycle maximums: \_\_\_\_\_

Reference # for call to insurance carrier: \_\_\_\_\_

NOTES

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